Year 1
Direct Support Professional Training

Resource Guide

Internet Version

Session #5
Wellness:
Responding to Individual Needs

Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services

1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	Communication	3 hours
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	Wellness: Medications	3 hours
5	**Wellness: Responding to Individual Needs**	**3 hours**
6	Positive Behavior Support	3 hours
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	Teaching Strategies: Postive Feedback and Natural Times to Teach	3 hours
9	Daily Living	3 hours
10	Individual Rights, Laws and Regulations	3 hours
11	Leisure and Recreation	3 hours
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Health Care Assessment, History and Plan
- Personal Hygiene
- Personal Health Advocacy
- Signs and Symptoms (of Health Problems)
- Medical Emergency
- First Aid
- Emergency Services

Cautionary Statement

The material in this module is not intended to be medical advice on personal health matters. Medical advice for a particular person should be obtained from a licensed physician. We urge you to talk not only with physicians but also with other health care providers, including pharmacists, nurses, dietitians, and therapists of various kinds. These specialists, along with advocates and emergency service personnel, can broaden your understanding of the fundamentals covered in this module.

Your In-Class Review Notes

Here are some review questions about the presentations and activities for this class session.

1. **How do health assessments relate to health care plans? What are two elements of an initial health assessment?**

2. **Why are physical examinations helpful?**

3. **In helping people care for their teeth and nails, what should the DSP do?**

4. **What should you do to get ready for an appointment with a health care professional?**

5. **What is the relationship between the following: (a) observation; (b) change; (c) objective signs; and (d) subjective feelings?**

6. **What is a medical emergency? When should a person call 911?**

Information Brief

Health Assessment and Planning

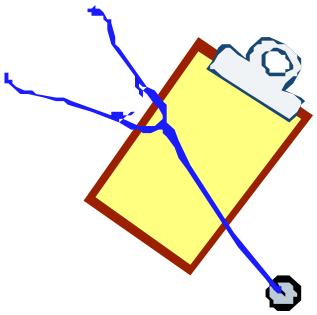
Introduction

This module is about *responding to the health needs of the individual*. This involves (1) determining health needs; (2) planning ways to meet such needs; (3) carrying out those plans; (4) evaluating the results; and (5) making adjustments in services and supports that result in the "best possible health" of the individual. Proper health care is an on-going process. New needs arise over time, triggered by a host of factors, including simply the effects of aging. All community-care facilities (CCFs) must assure that each person has access to all needed medical and dental services and that their health care needs are met.

By law, CCFs provide *non-medical, residential services*. Over the years, however, legislative and regulatory changes have permitted certain health-related services to be delivered in CCFs. These exceptions include (a) hospice care in homes for the elderly; (b) certain specialized health care services for medically fragile children; and (c) incidental medical care for adults.

It is unlawful for CCF's to accept (or retain) individuals who have certain health care needs that require nursing services. Individuals with *restricted health conditions* (for example, the need for oxygen, insulin-dependent diabetes) can be served in CCFs if certain standards are met. These include:

- ✓ Willingness of the licensee to provide needed care;
- ✓ The condition being stable (or, if not, temporary and expected to return to what is normal for the individual);
- ✓ The person being under the care of a licensed professional; and/or
- ✓ A licensed health professional providing training and supervision to unlicensed staff assisting with special or incidental medical care.



Services and supports to children and adults with special or incidental medical care needs are beyond what is covered in this module, and will not be discussed further. Staff working in homes that provide special or incidental medical care must be trained and supervised by a licensed health care professional and follow an individual Health Care Plan.

Initial Health Assessments

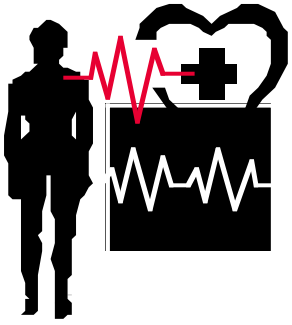
Health assessments identify health problems or needs. Plans are developed by health care professionals in response to identified problems. Plans provide direction for DSP, health professionals, and others in assisting the individual to meet their needs. Plans include a means to determine if what is being done is having the desired effect. A current physical examination and a health history are two essential elements of a health assessment.

A *Physician's Report for Community Care Facilities*, should be completed by the primary care physician when he/she is conducting a physical examination. The *Physician's Report* (a sample follows) describes an individual's current health status, including: the results of tuberculosis testing; the presence or absence of allergies and communicable diseases; whether the person is ambulatory or non-ambulatory; physical health care needs; mental health status; capacity for self-care; over-the-counter medications and conditions for use; and, a list of prescribed medications being taken by the person.

In order to have a complete understanding of an individual's health care needs, it is also important to know and understand an individual's health history. The health history includes information about past (and/or present) illnesses, a family medical history, and a medications history. A typical form for the completion of a comprehensive assessment is the *Health History (*sample follows). Information about each person's health history is obtained from discussion with the individual and those who have known the individual in the past, and from a review of records. Informants may include the individual, parents, regional center service coordinator and clinicians, previous care givers and the primary care physician.

If a person is changing his or her primary care physician, it is a good idea to have the person (or authorized representative) request a copy of his/her medical records be sent to the new primary care physician. It is very important that the new physician have the individual's complete health history. The *Health History* form may be useful to the DSP in gathering this information and sharing it with the primary care physician and others involved in planning and provision of services.

This information from both the *Physician's Report and the Health History* helps those caring for an individual to identify needs for health care services and to assist them in planning for and meeting those needs. For example, information from the *Health History* about a family history of breast cancer may affect plans as the person is at higher risk and may benefit from more frequent or earlier screening.



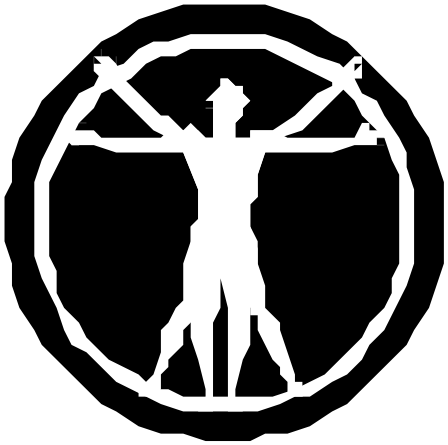
Health Care Needs or Problems

The DSP should be familiar with the current health status and health history of individuals they work with and be knowledgeable and competent in implementing plans for health care. In order to meet individual health care needs the DSP should be able to identify and understand:

- On-going health maintenance needs, for example, regular physical and dental examinations and screening; and

- How to meet on-going health care needs.

The regional center's Individual Program Plan (IPP) provides information and direction for proper health care and identifies specific responsibilities of the DSP. The IPP is developed by a planning team which includes at a minimum the individual, parents (authorized representative), regional center service coordinator. Planning should involve others including service providers, regional center clinicians, the primary care physician and other invited by the individual to participate. [An *Appraisal/Needs and Services Plan* form (sample follows) is a licensing form that may be used in addition to the IPP.] Problems or needs should drive plans, and plans should provide sufficient direction to everyone, including the DSP, involved in the person's health care to support the individual to meet each need, specifying who, what, how and when and a method of evaluating progress. **Good care depends upon the coordinated, effective teamwork of all of the people involved in the individual's health care.**



STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY: | TELEPHONE:

ADDRESS: NUMBER STREET CITY

LICENSEE'S NAME: | TELEPHONE: | FACILITY LICENSE NUMBER:

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME: | TELEPHONE:

ADDRESS: NUMBER STREET CITY | SOCIAL SECURITY NUMBER:

NEXT OF KIN: | PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE: | HEIGHT: | SEX: | WEIGHT: | IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ YES ☐ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE | DATE OF LAST TB TEST:

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
B) ☐ YES ☐ NO If YES, list below:

ALLERGIES
C) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
D) ☐ YES ☐ NO If YES, list below:

Ambulatory status of client/resident: ☐ Ambulatory ☐ Nonambulatory

Health and Safety Code Section 13131 provides: "Nonambulatory persons" means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. The determination of ambulatory or nonambulatory status of persons with developmental disabilities shall be made by the Director of Social Services or his or her designated representative, in consultation with the Director of Developmental Services or his or her designated representative. The determination of ambulatory or nonambulatory status of all other disabled persons placed after January 1, 1984, who are not developmentally disabled shall be made by the Director of Social Services, or his or her designated representative.

LIC 602 (7/96)

(OVER)

I. PHYSICAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	COMMENTS:			
	YES (Check One)	NO (Check One)	ASSISTIVE DEVICE	COMMENTS:
1. Auditory Impairment				
2. Visual Impairment				
3. Wears Dentures				
4. Special Diet				
5. Substance Abuse Problem				
6. Bowel Impairment				
7. Bladder Impairment				
8. Motor Impairment				
9. Requires Continuous Bed Care				

II. MENTAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	COMMENTS:			
	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able To Follow Instructions				
3. Depressed				
4. Able to Communicate				

III. CAPACITY FOR SELF CARE: ☐ YES ☐ NO	COMMENTS:		
	YES (Check One)	NO (Check One)	COMMENTS:
1. Able to care For All Personal Needs			
2. Can Administer and Store Own Medications			
3. Needs Constant Medical Supervision			
4. Currently Taking Prescribed Medications			
5. Bathes Self			
6. Dresses Self			
7. Feeds Self			
8. Cares For His/Her Own Toilet Needs			
9. Able to Leave Facility Unassisted			
10. Able to Ambulate Without Assistance			
11. Able to manage own cash resources			

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	_____
2. Constipation	_____
3. Diarrhea	_____
4. Indigestion	_____
5. Others *(specify condition)*	
_____	_____
_____	_____

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

PHYSICIAN'S NAME AND ADDRESS:	TELEPHONE:	DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE	ADDRESS:	DATE:

97 35381

Health History

Biographical information:

Name_____ Gender: ❒ Male ❒ Female Date of birth_____
Nature and origin of disabling condition:_____
Where lived over the past few years:

From/to (MM/YY)	Address (Street, City, State, ZIP)	Person(s) lived with	Phone#

Sources of information (medical records; informants; individuals; etc.):_____

Social Security No._____ Blood type:_____
Medicare No._____ Medi-Cal No._____
Emergency Contact_____ Relationship_____
Phone (days)_____ (other)_____
Emergency Contact_____ Relationship_____
Phone (days)_____ (other)_____
Guardian/conservator_____ Phone:_____
RC Service Coordinator_____ Phone:_____
Primary Physician_____ Phone:_____
Dentist_____ _____

Basic current health information

Allergies_____
Special Medical Conditions_____
Regularly Taken Medications (name; reason, schedule)_____

Personal illnesses

Do you have, or have you had, any of the following?	Yes	No	Year
Allergies	❒	❒	
Anemia	❒	❒	
Angina or chest pain	❒	❒	
Anxiety or Panic Attacks	❒	❒	
Arthritis	❒	❒	
Asthma	❒	❒	
Blood infection	❒	❒	
Breathing problem	❒	❒	
Cancer or Leukemia	❒	❒	
Chicken Pox	❒	❒	

Name: _____

	Yes	No	Year
Compulsiveness, persistent	❒	❒	_____
Constipation	❒	❒	_____
Convulsions or seizures	❒	❒	_____
Depression (persistent 'down' mood)	❒	❒	_____
Diabetes or Hypoglycemia	❒	❒	_____
Diarrhea, persistent	❒	❒	_____
Ear Infection	❒	❒	_____
Emphysema	❒	❒	_____
Encephalitis	❒	❒	_____
Glaucoma or cataracts	❒	❒	_____
Hay Fever, Hives or Skin Rash	❒	❒	_____
Headaches, persistent	❒	❒	_____
Hearing Voices	❒	❒	_____
Heart Attack	❒	❒	_____
Heart Murmurs	❒	❒	_____
High Blood Pressure	❒	❒	_____
Immune System Problems	❒	❒	_____
Kidney Trouble	❒	❒	_____
Knee or Hip Replacement	❒	❒	_____
Liver Problems or Hepatitis	❒	❒	_____
Meningitis	❒	❒	_____
Obsessiveness, persistent	❒	❒	_____
PKU	❒	❒	_____
Pneumonia	❒	❒	_____
Reflux or Heartburn	❒	❒	_____
Rheumatic Fever or Rheumatic Heart Disease	❒	❒	_____
Scarlet Fever	❒	❒	_____
Seizures	❒	❒	_____
Stroke	❒	❒	_____
Stomach Ulcers	❒	❒	_____
Thrombophlebitis or Blood Clots	❒	❒	_____
Thyroid Trouble, Goiter	❒	❒	_____
Tuberculosis	❒	❒	_____
Vomiting, persistent	❒	❒	_____
Whooping Cough	❒	❒	_____
Other (specify:_____)	❒	❒	_____
Other (specify:_____)	❒	❒	_____
Other (specify:_____)	❒	❒	_____

Name: _____

Family Medical History

Family member/Name	Health status	Major illnesses*	Cause of death	Age of death
Father				
Mother				
Sibling				
Grandparents				
Others (e.g., uncles, aunts, cousins)				

*Be sure to include arthritis, cancer, diabetes, heart condition, lung disease, mental illness, and stroke.

Medication History

Drug, Dose, Frequency*	Purpose used for	When began?	Stop-ped?	Problems, Side Effects, Allergic Reactions, etc.

*Be sure to include antibiotics that have been problematic, as well as OTC medications

Date Completed: _____ Signed: _____

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

APPRAISAL/NEEDS AND SERVICES PLAN

CLIENT'S/RESIDENT'S NAME	DATE OF BIRTH	AGE	SEX ☐ MALE ☐ FEMALE	DATE
FACILITY NAME	ADDRESS			CHECK TYPE OF NEEDS AND SERVICES PLAN: ☐ ADMISSION ☐ UPDATE
PERSON(S) OR AGENCY(IES) REFERRING CLIENT/RESIDENT FOR PLACEMENT			FACILITY LICENSEE NUMBER	TELEPHONE NUMBER ( )

Licensing regulations require that an appraisal of needs be completed for specific clients/residents to identify individual needs and develop a service plan for meeting those needs. If the client/resident is accepted for placement the staff person responsible for admission shall jointly develop a needs and services plan with the client/resident and/or client's/resident's authorized representative referral agency/person, physician, social worker or other appropriate consultant. Additionally, the law requires that the referral agency/person inform the licensee of any dangerous tendencies of the client/resident.

NOTE: *For Residential Care Facilities for the Elderly, this form is not required at the time of admission but must be completed if it is determined that an elderly resident's needs have not been met.*

BACKGROUND INFORMATION: *Brief description of client's/resident's medical history/ emotional, behavioral, and physical problems; functional limitations; physical and mental; functional capabilities; ability to handle personal cash resources and perform simple homemaking tasks; client's/resident's likes and dislikes.*

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS
SOCIALIZATION — Difficulty in adjusting socially and unable to maintain reasonable personal relationships				
EMOTIONAL — Difficulty in adjusting emotionally				

LIC 625 (5/93) CONFIDENTIAL

(Continued on Reverse)

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS
MENTAL — Difficulty with intellectual functioning including inability to make decisions regarding daily living.				
PHYSICAL/HEALTH — Difficulties with physical development and poor health habits regarding body functions.				
FUNCTIONING SKILLS — Difficulty in developing and/or using independent functioning skills.				

We believe this person is compatible with the facility program and with other clients/residents in the facility, and that I/we can provide the care as specified in the above objective(s) and plan(s).

TO THE BEST OF MY KNOWLEDGE THIS CLIENT/RESIDENT DOES NOT NEED SKILLED NURSING CARE.

LICENSEE(S) SIGNATURE ▶ _____ DATE _____

I have reviewed and agree with the above assessment and believe the licensee(s) other person(s)/agency can provide the needed services for this client/resident

CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S)/FACILITY SOCIAL WORKER/PHYSICIAN/OTHER APPROPRIATE CONSULTANT SIGNATURE ▶ _____ DATE _____

I/We have participated in and agree to release this assessment to the licensee(s) with the condition that it will be held confidential.

CLIENT'S/RESIDENT'S OR CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S) SIGNATURE ▶ _____ DATE _____

Activity: Toward a Health Care Plan

Information about Walter: Walter is a 36 year old and has Down Syndrome. He has lost his left eye and has a glass eyeball that occasionally gets goopey with whitish-gray discharge. He doesn't like to brush his teeth and resists the efforts of staff to help him brush his teeth. When he does brush his teeth, he doesn't do a very good job. Walter has occasional constipation. He is overweight and doesn't get much exercise. He will eat fruits and vegetables, but prefers hamburgers and french fries.

Health Problems: What health and health-related problems (or needs) does Walter have?

#1 _____

#2 _____

#3 _____

#4 _____

#5 _____

What questions would you ask Walter's physician and others involved in his health care (parents, regional center clinicians and others who know Walter well) to learn how you can assist Walter to meet the health care needs you identified above? Limit your response to only three of the identified needs.

REMEMBER: Health care plans include (1) identification of a need; (2) plans to meet the need (Who will do what? How often? When?); (3) a method to evaluate the results to determine progress.

Problem: ***Questions to Ask:***

#_____

#_____

#_____

Information Brief

Meeting Medical and Dental Health Care Needs

Scheduling Routine Medical and Dental Examinations

A complete physical examination provides a great deal of useful information, including baseline information (for example, blood pressure, weight) against which subsequent test results can be compared. Each person's IPP should specify how frequently routine physical and dental examinations are to be obtained. The planning team decision will be based upon the individual's current health status, family history, age and gender.

Historically, an annual physical examination was the norm. Increasingly, physicians are recommending age-gender specific schedules for physical examinations and screening. The chart in this guide titled *Preventive Health Care for Children, Adolescents and Adults* provides recommend frequency for health check-ups, vision and hearing teats, Tuberculosis, Pelvic/Gynecological exams and many other screening exams, as well as, recommended schedule for immunizations.

Generally speaking, if you are 18 to 64 years old, you should get health check-ups every 1-3 years, depending upon your health and risk factors. For those who are 65 years of age or older, the individual should get a health check-up every year. Routine examinations should include the physician talking to and observing the individual; measurement of height, weight, and blood pressure; checking immunizations and bringing then up to date; and, doing any procedures called for because of risk factors, age, or gender. A vision and hearing screening may also be included. It is important that a person have routine health check-ups with their physician even if they are not sick or having problems.

Scheduling an Appointment

Call the physician and arrange a mutually convenient time. If the visit is routine, the physician may only schedule a 15 minute appointment. Be sure to mention any specific concerns the individual has that may require more of the physician's time, for example, discussion of an emerging health issue. Also, if the person gets anxious if he/she has to sit and wait for the doctor or has some other special need, mention these when making the appointment and ask for accommodations. Many physician's offices are understanding, and will make arrangements to make things comfortable.

Preparing for an Appointment

Here are some tips to help you and the person in your care prepare for the physician visit and make the most of your time together:

1. Prior to the visit, talk with the individual and other involved in his/her health care to identify any health concerns;
2. Bring a written list of any concerns and questions you and/or the individual may have;
3. Make sure the questions get asked, whether by you or the individual;
4. Make sure you understand what the physician is saying and don't be afraid to ask for clarification;
5. Ask any questions you have about diet, exercise, or smoking;
6. Ask about treatment options;
7. Tell the physician about all medications the person is taking;
8. When the physician writes a prescription, ask questions about the medication;
9. Ask about next steps to be sure you understand what the physician wants done.
10. Encourage the individual to ask questions and express concerns.

Always arrive early or on time for each appointment. If you cannot get there, call well in advance and reschedule.

Recognizing and Advocating for Age and Gender Health Screening Needs

According to *Kaiser Permanente's Healthwise Handbook* (1998):

"Many doctors used to recommend a complete physical every year. Now, most doctors recommend specific medical exams based on age, gender, and risk factors (for example, diabetes, being overweight, high blood pressure, breast cancer in the family). These exams are more effective than the annual physical in detecting treatable illness."

The following health screening guidelines are based on the Report of the U. S. Preventive Services Task Force, which is regularly modified and updated as new evidence accumulates on the cost and effectiveness of screening.

Self-exams
Health screening starts with self-examination. If the individual is able (with or without prompting), he or she should complete regular (or at least monthly) breast and testicular self-exams. When conducting a self-examination, one is looking for change in tissue density (lumps), contours, and the like. Self-examination of a woman's genital area can also be helpful. Here, one is looking for sores, warts, red swollen areas. A physician, nurse or health educator can help individuals in your care learn procedures for self-examinations.

Clinical breast and pelvic exams
Clinical breast examinations (in women) should start at age 20, and be done every 1-2 years. (If the woman has a mother or sister with breast cancer prior to menopause, an earlier start may be warranted.) These exams are done by physicians, practitioners, or gynecologists. A pelvic examination, which includes a pap smear, should be done every 1-3 years starting when a woman becomes sexually active or upon reaching adulthood, whichever occurs earlier. Pap smears detect 90-95% of cervical cancers.

Mammograms
Here, X-rays or ultrasound are used to detect suspicious lumps, tumors, or cysts. Beyond menopause, mammograms save lives, reducing deaths from breast cancer by a third. Most guidelines call for mammograms every 1-2 years after menopause, starting earlier if breast cancer is evident within the family.

Breast cancer is the leading cause of cancer deaths among women 40 to 55 years of age. In accordance with the above guidelines, breast self-examination, clinical breast exams and mammograms can save lives.

Screening for prostate cancer
A prostate cancer screen by a doctor should be done starting at age 50 and yearly thereafter. Cancer of the prostate gland is the most common cancer in men, and the second leading cause of cancer deaths in men. Most such cancer, however, occurs after age 65. The risk is higher-than-average among African-American men, men who eat a high-fat diet, and men with fathers and brothers who have had prostate cancer.

Screening for sexually-transmitted diseases (STDs)
STDs are at epidemic levels in the United States. If a person is sexually active, it is wise to screen for some STDs yearly: Chlamydia and Gonorrhea, in particular. Symptoms for some STDs are difficult to detect (for example, Chlamydia), others may include painful urination (for example, Gonorrhea), jaundice (Hepatitis B), and small, red blisters (for example, Syphilis). If signs or symptoms occur, they need to be brought to the physician's attention right away.

In general, STDs can be prevented by not having sex or by using a latex condom every time a person has sex, whether vaginal, anal, or oral. Hepatitis B and HIV/AIDS can also be spread through exchange of blood (and semen, in the case of HIV).

Other exams
Many other tests should be routinely done periodically at or beyond certain ages. These examinations include blood pressure, sigmoidoscopy (to detect colon cancer) or some other colon cancer screen, and cholesterol readings. Refer to the Preventive Health Care for Children, Adolescents and Adults (following) for information about specific examinations.

Reported Low Rate of Gender Related Screening

A major concern is the very low rate at which gender-related health screening takes place for men and women with developmental disabilities. Findings from a recent review of health records (for one year for women receiving regional center

Preventive Care for Adults

To keep yourself healthy, it is important to have health check–ups with your doctor even if you are not sick or having problems. If you are 18-64 years old, you should get health check-ups every 1 – 3 years, depending on your health and your risk factors. For those who are 65 years old or older, you should get health check-ups every year. If you are a new member of the health plan, you should get a health check-up within 4 months with your primary care provider. Below is a list of tests that should be done for your age group, but your doctor may want to do some tests more often.

TESTS	19 to 39 years	40 to 59 years	60 to 64 years	65 & older
Height & weight	every 3 years	every 3 years	every 3 years	every year
Blood pressure	every 2 years	every 2 years	every 2 years	every year
Stool blood *(colorectal cancer screen)* **OR** Sigmoidoscopy *(colorectal screen)*		at 50 and every year after at 50 and every 10 years after	every year every 10 years	every year every 10 years
Cholesterol *(for men)*	at 35 and every 5 years after	every 5 years	every 5 years	every 5 years
Cholesterol *(for women)*		at 45 and every 5 years after	every 5 years	every 5 years
Immunizations				
Diphtheria - Tetanus vaccine	every 10 years	every 10 years	every 10 years	every 10 years
Tuberculosis *(TB)* test	for people at high risk; every 2 years	for people at high risk; every 2 years	for people at high risk; every 2 years	for people at high risk; every 2 years
Hepatitis B test	18 to 35 and for people at high risk	for people at high risk	for people at high risk	for people at high risk
Pneumovax *(to protect against pneumonia)*				at 65 & as doctor recommends
For Men				
Prostate Cancer Screen *(by a doctor)*		at 50 and every year after	every year	every year
Testicular self-exam *(check for lumps)*	monthly	monthly	monthly	monthly
For Women				
Breast exam by doctor *(to check for cancer)*	every 3 years	every year	every year	every year
Breast self-exam *(do 1 week after menstrual period; check for lumps)*	monthly	monthly	monthly	monthly
Mammogram *(breast x-ray)*	at 35 if you have a family history, you can decide when to have one	at 40 to 49 you can decide when to have one; at 50 to 69 every year	at 50 to 69 every year	at 50 to 69 every year; at 70+ you can decide when to have one
Pap smear *(to check for cervical cancer)*	every 1-3 years	every 1-3 years	every 1-3 years	every 1-3 years

Source: *Adapted from a Newsletter insert, published by* Partnership Health Plan of California (PHC), 1998. PHC is a county-based Health Maintenance Organization, serving Medi-Cal patients in Solano and Napa counties.

Preventive Care for Children and Adolescents

The health plan recommends regular health check-ups for children and teens. Regular health check-ups can help you learn ways to keep your child healthy and to find out about possible health problems early on. As a member, your child or teen is eligible to have preventive health check-up as part of the Child Health and Disability Program (CHDP). The plan recommends health check-ups at the same ages as recommended by the American Academy of Pediatrics and CHDP as shown in the chart below. Your doctor's staff or your doctor should ask questions about your child's health history, growth, development and behavior during healthy check-ups. During health check-ups, you can also expect to learn ways to prevent injury and to learn what to expect as your child grows. Your doctor may recommend additional visits or screenings if needed.

	Ages for Infants and Toddlers (age in months)	**Early Childhood** (age in years)			**Middle and Late Childhood** (age in years)			**Adolescence** (age in years)									
HEALTH CHECK-UPS History, height, weight, blood pressure (starting at age 3) and other important assessments	At newborn, 2-4 days (if needed) 1,2,4,6,9,12,15, 18 and 24 months	3	4	5	6	8	10	11	12	13	14	15	16	17	18	19	20	21
Vision test		•	•	•			•		•			•			•			
Hearing test		•	•	•			•		•			•			•			
Test for Anemia *(blood test)*	Between about 7-9, 13-15, and 24 months	•		•		•			•			•				•		
Urine Test				•		•			•			•				•		
Test for Lead (blood test). Your doctor or staff will also ask questions about possible exposure to lead at check-ups between 2 months and 4-5 years	At 10-12 months and at 24 months																	
Tuberculosis test (TB) (Also recommended for children at higher risk)						•						•						
Pelvic/Gynecological Exam	Recommended for sexually active females and females age 18 years and older																	

Recommended Schedule of Immunizations from Birth to 16 Years Old

Immunizations (shots) protect your child from many serious diseases. It is important to complete all shots in order to help your child to be fully protected. Keep your child's shot record in a safe place and bring it with you to your child's doctor appointments. If you think your child may have missed a shot, or should not have a shot let your child's doctor know. Your doctor may recommend a different shot schedule in order to catch up on missed shots.

AGE	DtaP or DTP (diphtheria, tetanus, pertussis)	POLIO	POLIOMMR (measles, mumps, rubella)	HIB (haemophilus influenza type B)	HEPATITUS B	VARICELLA (chicken pox)
At birth					✿ (between birth-2 mo)	
2 months	✿	✿		✿	✿ (between 1-4 mo)	
4 months	✿	✿		✿		
6 months	✿			✿ (If required)		
6-18 months		✿	✿ (12-15 months)		✿	
4-6 years	✿	✿	✿			
11-12 years	✿ (Tetanus/ Dip booster)				✿ (If child has not already had 3 doses)	✿ (If child has not had vaccine or chicken pox)
14-16 years	✿ (if needed)					

services in one California County) indicate that:

- ✓ only 22% of women 40 years of age or older had a mammogram during the year; and
- ✓ only 4% of the women 18 years of age or older had a pap smear.

In effect, this means that older women were getting mammograms about every five years (recommended every 1-2 years after menopause), and pelvic examinations about every 20 years (recommended every 1 to 3 years for all women). Clearly, these rates are unacceptable. Among non-disabled women, 80% have a pap smear every two years. It is important for the DSP to be aware of age-gender related screening guidelines in order to assist in the identification of individual needs.

Routine dental examinations
Yearly dental examinations for each individual should include (1) professional cleaning; (2) X-rays; (3) a visual examination of the teeth and mouth by the dentist and (4) the dentist reading the X-rays to identify any problems needing follow-up. If additional work is needed, follow-up visits are scheduled.

Denti-Cal (dental insurance) routinely covers one dental office visit per year. If a person has a health condition, for example cerebral palsy, that calls for seeing the dentist more often, dentists can apply for a Denti-Cal treatment authorizations to see the person more frequently.

Minor Illnesses

If a person has some of the following symptoms, he or she probably has a cold or the flu: stuffy nose; runny nose; cough; sore throat; headache; fever; tiredness; and/or muscle aches. Both are viral infections. Plenty of rest, fluids and over-the-counter medicines (with a physician's order) are probably all that the person needs to get better. Keep the person comfortable, while his or her body fights off the infection. Remember, thorough handwashing can help prevent the spread of infection.

Especially if the person has impaired physical health (for example, medical fragility), be sure to call the physician and see if he or she should be seen. While antibiotics will not affect the course of a viral infection, secondary bacterial infections can arise, and need to be addressed quickly.

Managing Chronic Health Care Conditions

We have already spoken about the importance of health care plans. This applies to both minor and major illnesses. For major illnesses, such as asthma or diabetes, more intensive planning, training, supervision, and other support are needed. As this curriculum is designed for *all* DSPs, details on proper care or management of chronic health conditions will not be discussed. Talk with the person's physician and other health care providers. Your regional center nurse may be helpful, and should have procedural guidelines (called *protocols)* for most chronic health conditions requiring specialized care.

Personal Hygiene (Hair, Skin, and Nails) and Care of Teeth

Hair
Hair should be shampooed regularly. Skin cells flake off. If the skin cells are on the scalp, they mix with oil and dust and are called ***dandruff***. Frequent and vigorous shampooing may help to prevent dandruff. If a person develops dandruff, a dandruff shampoo may help prevent flaking.

Occasionally, people get head lice (tiny, white, wingless insects) that feed on the skin and blood. Lice lay tiny eggs, called nits, and cause mild to severe itching and rash. If a person in your care gets lice, check with their physician. The physician typically recommends treatment with over-the-counter medications (medicated shampoo).

Anyone coming in contact with a person who has lice can get lice (it's very contagious). Indirect contact with clothing of the infected person may spread lice to others. Clothing and linens should be washed in hot soapy water or dry cleaned. Follow the physician's recommended treatment and wash clothing and linens to guard against spread and re-infestation.

REMEMBER: Over-the-counter medications cannot be used in a CCF without a physician's specific written order.

Skin
Guard against ***sunburn***, by wearing a broad-brimmed hat and loose clothing, and staying out of direct sunlight. If spending a lot of time out of doors in sunlight during the hottest part of the day, use a sun screen with a sun protection factor (SPF) of at least 15.

Skin breakdown is a serious and ever present concern for people who use wheelchairs and/or do not move about and change positions. When skin breakdown occurs or is suspected, the person must be seen by a physician immediately and treated according to their directions. Skin breakdown can be prevented by frequent moving about and/or changing positions and keeping the skin dry and clean.

Athlete's foot (tinea pedia) and Jock Itch (tinea cruris) are fungal infections. Like bacteria, fungi grow best in warm, moist areas of the skin, such as between the toes or in the groin. Problems can be prevented by thorough drying off, wearing sandals or shoes that "breath", wearing cotton underclothes and socks, and using talcum powders. Be sure to clean both areas.

The number of skin problems is very long. Here are some additional skin problems to be concerned about:

acne
bee stings
boils
chickenpox
cool, clammy, pale skin
cradle cap
diaper rash
eczema
fungal infections
hot, dry and red skin
ingrown toenails
itching
jellyfish stings
melanoma
mosquito bites
atopic dermatitis
blisters
burns
cold sores
corns & calluses
cuts
dry skin
frostbite
hives
impetigo
insect bites
jaundice
Lyme disease
moles
pimples

plantar warts
prickly heat
rashes
roseola
scrapes
skin cancer
unusual sores
yellow skin
poison ivy, etc.
psoriasis
ringworms
scabies
shingles
spider bites
warts

Some skin problems are very serious. Others are uncomfortable and passing. Some skin problems can be prevented, or at least minimized through diet, proper clothing, and other actions. Some skin problems may be spread by contact, so remember to use handwashing and other infection control techniques. Always seek advice and treatment from the person's physician when new problems arise, or existing problem don't get better.

Teeth
Proper dental hygiene, combined with regular professional exams and cleaning, pays great dividends. The DSP can help by encouraging good dental hygiene practices, helping the person obtain any adaptive equipment needed (for example, large handle toothbrush), and offering training and assistance when needed. Individuals should:

- ✓ Brush their teeth at least twice a day, using a soft-bristle toothbrush;
- ✓ Fluoride toothpaste, and spending at least three minutes brushing all surfaces thoroughly, especially around the gum line. (It is the mechanical motion that loosens and sweeps away plaque.)
- ✓ Floss periodically and every day if possible.
- ✓ Purchase new toothbrushes frequently.
- ✓ Avoid long periods of time with sugary substances (or residue) in the mouth.

Nails
Fingernails and toenails should be kept trimmed and clean. Toenails should be cut straight across, so that the nail edges do not cut into the skin at the edge. Shoes should be loose enough in the toe box, so that pressure is not placed on the toe and nail. Ingrown nails can be quite painful, and infection can develop.

The services of a podiatrist may be particularly helpful when cutting toenails, especially if the person:

- ✓ Has diabetes (any foot infection can be very serious - **always consult the physician before trimming the toenails of someone with diabetes**);
- ✓ Has circulatory problems (for the same reason); and
- ✓ Has toenail fungus (specialized equipment may be needed and again there is risk of infection).

Be sure to ask the individual's physician for directions. Always seek medical attention if signs of infection occur: swelling, redness, red streaks extending from the area, discharge of pus, fever of 100 degrees F or higher with no other cause.

Information Brief

Vital Signs

Temperature

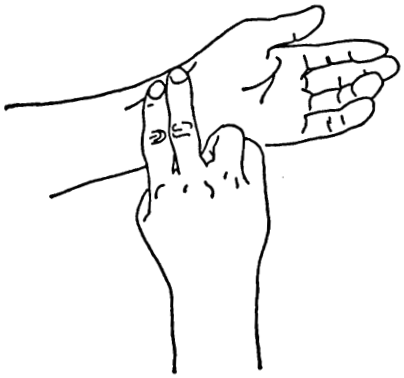
There are various methods of taking body temperature: (1) skin temperature (not very accurate); (2) ear temperature (very accurate); and (3) conventional glass thermometer (not very accurate). If a person's temperature is taken by a conventional thermometer: (1) wash the thermometer in cold or lukewarm, soapy water; (2) soak in alcohol; and (3) shake down the thermometer, so the reading is about 95 degrees F.

Typically, a person's temperature is taken under the tongue, with mouth closed (breathing through the nose), for several minutes. An oral thermometer should not be used for someone with a history of seizures, breathing through mouth, has just had oral surgery, or is unconscious.

Normal temperature is 98.6 degrees F. Anything within a degree either side (97.6 to 99.6) is considered normal. One can take a person's temperature under the armpit (with tip of the thermometer against dry skin and held in place by the arm), waiting 5 minutes (not 4). Electronic thermometers and pulse meters have dropped in price, and are very convenient for taking temperatures and pulses, either in the ear or at a person's fingertip.

Pulse

Typically, a person's pulse (beats per minute) is taken on the inside of the wrist, using the first two fingers pressed against the skin. Don't use your thumb, because you could end up "reading" your own heart beats. Count the number of beats over a fifteen second interval, and multiply by 4. Repeat the process to check for consistency. A normal pulse will be about 70 beats per minute. Anything from 50 to 90 is not uncommon for an adult. If it is hard to feel the pulse in the wrist, locate



Taking a Pulse

the carotid artery in the neck, just to either side of the windpipe, and press gently. Count the beats for 15 seconds, and multiple by 4 to estimate the number of beats per minute.

Respiration

Respiration (breaths in) is best counted without telling the person what you are doing. Awareness can change how a person breathes. It sometimes helps to be looking down, so as to see expansion of the chest. In children above the age of 7 through adulthood, a normal respiration rate will be 12 to 24 breaths per minute. Pay close attention not only to rate, but to wheezing, other sounds, ease or difficulty breathing.

Blood pressure

Blood pressure refers to the force of blood pushing against the walls of the blood vessel. Blood pressure for adults 18 years of age and older in the following categories:

- *Normal* – Below 130/85;
- *High-normal* – 130-139/85-89;
- *High* – 140/90 or higher.

Normal blood pressure for children is lower. The first number is the *systolic* measure, where the device that measures pressure by constricting the arm (or leg) first lets blood course through the vessels; the lower number is the *diastolic* measure that records pressure when the blood is no longer heard. High blood pressure (*hypertension)* is often called a "silent killer," because symptoms of any kind are rare, and such pressure, if persistent, can harden arteries and result in strokes, heart attacks, and kidney damage.

Blood pressure is affected by time of day (low at night; peak about 8 hours after awakening); emotions (stress increases blood pressure); weight (obesity typically increases blood pressure); activity level; excess sodium (salt) intake; excess alcohol consumption; and use of certain drugs, including birth control pills, steroids, decongestants, and anti-inflammatories. If high blood pressure is suspected, the DSP should make sure consistent readings are taken over a period of time. Blood pressure should be measured with the same device, same time of day, same arm (or leg), with individual in same position (for example, sitting up). Mark down anything that might have affected the blood pressure, such as exercise (for example, came in 10 minutes before from riding a bike).

Observation of Signs and Symptoms

Observation is about noticing ***change*** in a person's attitude, behavior, or communication (ABCs). When we observe changes, these are called *signs.* The sign may be of a *symptom* of a disease, illness, or injury. It may also mean that someone is getting better. Signs and symptoms are objective if the DSP can observe them using senses of:

- Sight (for example, rash; reddened area; swelling; rapid breathing; cloudy urine; tears; emotional outburst; aggression; property destruction; change in eating or sleeping pattern; etc.)

- Hearing (for example, labored or noisy breathing; crying; moaning with pain, coughing; yelling)

- Touch (for example, skin hot, moist, or cold; change in pulse rate; puffiness of skin; slight finger pressure results in wincing), or

- Smell (for example, fruity breath; foul smelling urine; foot odor; etc.).

It is helpful to distinguish objective *signs* and *symptoms* from subjective ones. The latter are experienced by the person. Subjective experiences are things a person feels (for example, pain) and describes to others. Aside from pain, several matters, such as ringing in the ears, headache, feelings of sadness, and the like, are important subjective experiences (or felt) which can be signs and symptoms of illness or injury, or changes in function. The distinction between the objective and the subjective is important, because many people with developmental disabilities have difficulty communicating with others. If a person cannot express how he/she feels, one may have to rely totally on objective indicators. This puts the pressure of discovery on the DSP and others. And, it makes awareness of health issues and diagnosis of health problems more challenging than it is for people who can communicate well. In general, more diagnostic tests will be needed to rule out possibilities.

In some cases, the objective and the subjective coincide. For example, a person may have a "feeling of dizziness," and crouch down and extend the arms to prevent a fall. Itching (an internal feeling) may coincide with scratching (something an outsider can see). Here is a list of some *signs* and *symptoms* of possible health issues:

skin rash	crying
bad dreams	rapid pulse
headache	nausea
vomiting	cloudy urine
gas pains	toothache
edema or swelling	coughing
ringing in the ears	depression
difficult, painful breathing	drainage
redness	not eating
elevated temperature	dizziness
inability to sleep	fruity breath
noisy breathing	chest pain
itching	scratching
chewing of hand	uneven sitting
head banging	head tilt
rubbing chest	rocking
pica	

Recognizing signs and symptoms of illness or injury, and responding appropriately can save lives.

Abnormal Pattern of Bowel Movement

Each person has a pattern of bowel movements that is "normal" for that person. Part of getting to know about individual needs is learning what the normal pattern of bowel movements is for that person. Once the normal pattern of bowel movements is established the DSP should look for any indication of a change. When an individual is not able to tell you that they had a bowel movement, the plan for that individual may include keeping a record of bowel movements.

Constipation is a symptom of a problem. Untreated constipation can lead to serious consequences including the need for surgical removal of the impacted fecal matter, rupture of the bowel and even death. People who are inactive, drink small amounts of fluids, have a low fiber diet, and take certain medications may be prone to constipation.

Signs and symptoms of a problem with constipation include:

1. A change in the normal pattern of bowel movements.
2. Loss of appetite, increase in sleepiness and fussiness.
3. Abdominal bloating.
4. Persistent abdominal pain (person is holding their abdomen).
5. Oozing of liquid stool.

If you observe any of these symptoms, call the individual's primary physician immediately.

Activity: Signs and Symptoms

DIRECTIONS: At each table, list at least three **signs** or **symptoms** observable by the DSP, or told to the DSP, in the following areas: (*NOTE:* You can ask a question to learn a symptom. For example, "Do you itch anywhere?")

1. Eyes, Ears, and Nose	
2. Mouth and Throat	
3. Head, Neck, and Shoulders	
4. Muscles and Bones	
5. Eating and Drinking	
6. Breathing	

7. Abdomen, Bowels, and Bladder	
8. Pain	
9. Sleeping	
10. Skin	
11. Thinking, feelings, emotions	
12. General level (or type) of activity	

Remarks, if any:

Information Brief

Seizures

Seizures call for mindful observation, especially when occurring for the first time in a person's life (or recent experience). Seizures were once classified as *petit mal* and *gran mal.* Today, the classification has two major categories, *partial* and *generalized.* This refers to origin in the brain. If a seizure begins locally in the brain it is *partial;* if it encompasses the entire brain, it is *generalized*. A *petit mal* is now known as an "absence seizure" (person stares off into space for a moment or two), and is not followed by confusion. Knowing general types of seizures is important to the neurologist in finding the right medication to prescribe. The DSP's job is not to diagnose, but to report on what happened during a seizure and, as appropriate, how long the person was unconscious.

Partial —

1. *Simple Partial*. Person remains conscious; seizure starts in a particular area of the brain; symptoms can involve movement, sensations, or feelings; an "aura" is a simple partial seizure, that may generalize.

2. *Complex Partial.* Consciousness is altered (person cannot remember it; confusion afterwards); often involve motor movements (lip smacking, tonic posturing, wandering about aimlessly).

3. *Partial*, *Secondarily Generalized*. Here, the partial seizure generalizes (i.e., quickly encompasses the whole brain).

Generalized —

4. *Tonic/clonic* (previously *gran mal).* – If truly a generalized seizure from the outset, there can be no "aura." This type of seizure results in a total extension of the trunk for some period of time (say, 15-30 seconds), followed by a number of seconds of shaking, followed by flexion and extension of the arms. With muscles contracting, blood pressure rises, pulse increases quickly, and dilation of the pupils occurs. The person may lose control of bodily functions and urinate. Recovery time can vary from a few minutes to a few hours.

5. *Absence* (previously *petit mal).* – These seizures, seen in some preadolescent children, typically last only a few seconds and often involve simple staring or eye blinking. Motor control is generally maintained.

6. *Myoclonic seizures.* – These often look like startle responses, and are often frequent but missed in persons with complex physical disabilities.

7. *Atonic seizures* (or, drop attacks). – These often result in facial or other head injuries. To prevent injury, many people subject to such seizures wear protective head gear.

8. *Tonic seizures.* – These seizures involve total body extension, stiffening of the extremities, and abrupt loss of consciousness. Such seizures only occur among individuals with mental retardation.

Status epilepticus, stemming from either a partial or generalized seizure, is potentially life-threatening. It is defined as either repetitive tonic/clonic convulsions (without recovery) or a single, prolonged seizure. Brain damage can occur after about 20 minutes of seizuring. Hence, if this is a person's first [known] seizure, and it lasts for 10 minutes or more, get help right away. Call **911.** Otherwise, call the physician, who may want to see the person at his/her office or at the Emergency Room. The physician may want to examine spinal fluid to rule out infection or do other tests. If a person has a history of seizures, consult with the neurologist. He may want to prescribe an "as needed" medication for repetitive seizuring on a given day. He may want you to call **911** after some number of minutes (say 10, 15, or 20), depending on the individual.

Seizures: what to do

When a seizure occurs, the DSP should do two things. One is to help protect the person from injury. The other is to observe the event carefully, and to document what occurred, including how long the person was unconscious (if loss of consciousness occurred). This information can be vitally important to the person's health care professional, especially if there is something new. Details are helpful in making a proper diagnosis which, in turn, is related to the intervention (for example, a particular drug or class).

Here are first aid rules for seizures:

1. Keep calm! The person is usually not suffering or in danger.

2. If falling, ease to the ground (or floor) and keep head away from objects (for example, furniture) to avoid injury. If a pillow is available, place under head.

3. Loosen tight clothing. Do <u>not</u> restrain movements.

4. If the person is unconscious, turn the person on side with face turned gently sideways or slightly down.

5. Do <u>not</u> put anything into the person's mouth.

6. Give nothing to drink.

7. Reassure the individual.

8. Stand by until consciousness returns and confusion abates. A test is whether the person can respond to questions or directions.

9. Allow a rest period (10-30 minutes for most people), then encourage participation in regular activities.

10. Document in individual's log.

It is rarely necessary to call Paramedics; however, in cases of prolonged seizures, recurring seizures, or injury, get professional advice and assistance.

Activity:
Understanding Seizures and Seizure First Aid

Watch the videotape from the Epilepsy Foundation of America, and then answer the following questions:

1. **When a seizure occurs, what is happening inside the person's brain?**

2. **To assist a person having a tonic-clonic (i.e., gran mal) seizure, what should you do? Not do? Why?**

3. **To assist a person having a partial seizure that doesn't generalize, what should you do? Not do? Why?**

4. **Under what circumstances involving a seizure would it be appropriate to seek medical care right away?**

Information Brief

Working with Health Care Professionals

Personal Health Advocacy

There are two ways of working with doctors and other health care professionals. One is to be an active partner, providing information, asking questions, discussing options, and contributing ideas as to what actions will be taken. The other, more traditional approach is to be *passive and accepting*, treating the doctor and others with great deference and asking them to do all the thinking and all the work. With rare exceptions, physicians prefer the former to the latter.

We strongly recommend the *active partner* approach, because it will improve the quality of care. Here are some basic attitudes that will help you to help individuals achieve the best possible health:

- ✓ *Believe* that every person is entitled to *quality care* and that you can make a positive difference in advancing the good health of the person in your care.
- ✓ *Be persistent.* Talk with people, ask for leads, and don't give up until the person in your care gets appropriate care.
- ✓ *It's never too early and it's never too late.* If the person in your care has not been well taken care of, don't continue that practice. Do the very best you can from here on out.
- ✓ If you don't take good care of your own health, or if you are skittish about seeing health care professionals, do not convey that to the person in your care by words, body language, or in any other way. If you cannot be confident and an *active partner*, get the help of someone who can.
- ✓ Don't be afraid to *ask for help* and any other support you need. There is a solution to most health care problems, but you may have to work to find it. You are not alone; other people (parents, regional center staff, other DSPs, friends) are there to help.
- ✓ *Be prepared.* Know what you want to talk about when meeting with health care professionals, many of whom are very busy. Keep good records, and summarize symptoms and signs accurately. If a diagnosis is unclear, and the person in your care uses few if any words, ask for tests to rule things in or out.
- ✓ *Choose a primary care physician with a reputation for good service.* Make sure he/she has hospital privileges at a nearby hospital. If the person in your care is hospitalized, stay with the person and advocate for prompt, good quality service.

Preparing for Medical Visits

Working in partnership with health care professionals calls for (1) a common goal (good quality care); (2) shared effort (each one doing the right thing); and (3) good communication. Here are five ways to be a good partner (adapted from materials by Kaiser Permanente):

1. Take good care of yourself and of others in your household.
2. At the first sign of a health problem, observe and record signs and symptoms. Record when, how long, how painful, etc. Measure and record vital signs, such as temperature and pulse rate.
3. Provide good care at home for minor problems; call the physician if minor problems don't go away or get worse.
4. Prepare for office visits, by doing your homework and being well organized. Prepare an *Ask-the-Doctor Checklist* like the one on the next page. Update and bring the list of signs and symptoms and of what has been done to help. Write down your main concern (chief complaint) and practice describing it. Write down any hunches about what is wrong. Write down the three questions you want answered the most. Bring along a list of medications the person is taking.
5. Play an active role in the office visit. Be candid and honest. Share your hunches and fears. Don't hold back. Get information regarding drugs, tests, treatments. Take notes. Keep good records.

Documentation and Follow-Up

Title 17 regulations require the residential service provider to keep an accurate record of office visits, phone calls, and other interactions with health care providers. (See sample forms and tips for staff in documentation later in this guide.)

Community Health Care and Safety Resources

In responding to a person's health care needs, you must often search out resources relevant to those needs and access them. Basic resources are:

1. a primary care physician (or group);
2. a dentist who does family or general dentistry;
3. specialists (for example, an eye doctor, gynecologist, podiatrist);
4. regional center clinicians;
5. other resources needed to address individual needs (for example, a support group for people struggling with kidney disease); and
6. information sources (for example, self-care handbooks; voluntary organizations like the American Cancer Society, the Heart Association; internet resources).

If there is a "need," there is something or someone who can help somewhere. It is up to the DSP and others on the individual's team to find and use services appropriate to each individual's needs.

Ask-the-Doctor Checklist

Date: _____

Individual's Name: _____

Step 1. Before the visit:

a. Complete the "Keeping Track and Initial Care," on the next page.
b. List all medications being taken:

Name	Purpose	Prescriber	Dose/frequency

Step 2. During the visit:

c. The main health problem is _____
_____
d. Signs and symptoms have been (from preceding page) . . .
e. Past experience with this problem has been _____
_____

Step 3. Write down:

f. Temperature _____ Blood pressure _____ / _____
g. The diagnosis (what's wrong) is _____
h. The prognosis (what might happen next) is _____
i. The home care plan is _____
_____
_____
_____

Step 4. For drugs, tests, and treatments, ask:

j. What's its name? _____
k. Why is it needed? _____
l. What are the risks? Expected benefits? _____
m. Are there alternatives? _____
n. What are the risks? Likely benefits? _____
o. *[for drugs]* How should it be taken? _____
p. *[for tests]* How do I prepare? _____

Step 5. At the end of the visit:

q. What danger signs should I look for? _____
r. When do I need to report back? _____
s. Are we to return for another visit? _____
t. Are we to phone in for test results? _____
u. What else do we need to know? _____
_____
_____
_____
_____

Keeping Track, and Initial Home Care

Date: _____

Step 1. Observe the Problem. Individual's Name: _____

a. What are the signs? symptoms?_____

_____

_____

_____

_____

_____

_____

b. When did they start?_____

_____

_____

c. Vital signs?

Temperature_____ Blood pressure_____/_____

Pulse_____ Breaths_____/minute

d. Thinking back:

Had the problem before? ❒ Yes ❒ No

What did you do for it?_____

_____

_____

Any change in life (stress, medications, food, etc.)?_____

_____

_____

Anyone else at home or work have these signs or symptoms?_____

_____

Step 2. Learn more about it.

e. Books, articles, web sites_____

_____

f. Advice from others (lay, professional)_____

_____

Step 3. Make an action plan.

g. "Tentative" diagnosis_____

h. Home care plan_____

_____

_____

i. When to call the doctor_____

Step 4. Evaluate progress.

j. Are your actions working?_____

_____

_____

Log of Health Care Visits and Consultations

Name:_____ DOB:_____

Date	Health care professional (name)	Phone? Y N	Reason/ Subject	Outcome/ Result	Follow-up or Notes (e.g., meds)

Smith Family Care Home, 1234 Main Street, Any City, CA 90000. Ph: (123) 456-7890

Activity:
Recording Visits and Phone Calls with Health Care Providers

Client's Name: Jane Doe DOB: 7/30/74

Events:

1. It is March 27th. Over the past month, Jane Doe, who is 5′ 2" tall, and currently weighs 175 lbs., gained 7 lbs. She and her care-provider are concerned about her weight. They call her primary care physician, Dr. Burns, whose front-office staff schedule an appointment for April 10.

2. On April 10, Jane is seen by Dr. Burns. At the office, the nurse writes down Jane's complaint (being overweight; rapid recent weight gain), and takes a few measures: Weight: 178 lbs.; Pulse: 76; Blood pressure: 140/92. Dr. Burns talks with Jane and Mrs. Smith, the care-provider, and does some checking with his stethoscope, a light, and tongue depressor. He orders some blood tests at a local lab. He learns that Jane, in a rush to get to her job, typically skips breakfast. She began working at a fast food restaurant six weeks ago, and eats her lunch there (sometimes 2 double-hamburgers and 2 large orders of French fries). Dr. Burns recommends that Jane (1) eat breakfast at home; (2) cut back to 1 hamburger and 1 order of French fries at lunch (or, even better, a grilled chicken sandwich and a small salad); (3) begin walking at least one mile each day; and (4) come back in for a blood pressure check in three months.

3. The next day, April 11th, Jane has blood drawn at the lab used by Dr. Burns's patients, and the lab says they will fax the results to Dr. Burns. They say "no news is probably good news," if you don't get a call from Dr. Burns's office about the lab work.

4. A month later, concerned that Jane hasn't lost any weight (but hasn't gained any either), Mrs. Smith calls Dr. Burns's office, and after checking with him, his nurse asks Jane to come in the next day (May 15) for a blood pressure check.

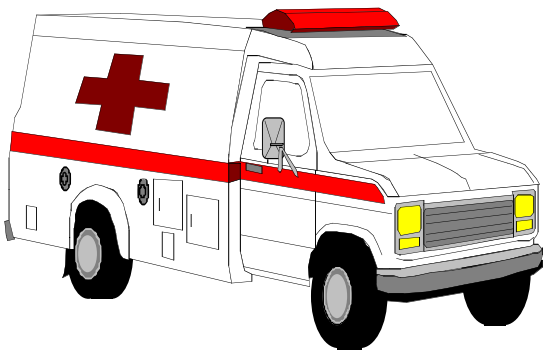
5. On May 15, Jane has her blood pressure checked, and it is 138/86. Her pulse is 76. Her weight at the office is 174 lbs. The nurse asks questions about breakfast, lunch and walking; encourages Jane (and Mrs. Smith) to continue their effort; and no change is made in Jane's scheduled appointment with Dr. Burns on July 7th.

Information Brief

Medical Emergencies

What is a Medical Emergency?

A medical emergency is an unexpected event calling for first aid, followed by prompt medical attention. Some emergencies call for an immediate response to protect life. All emergencies call for prompt medical attention, either by calling **911,** and having paramedics involved, or by calling a Poison Control Center (**1-800-8-POISON**) and getting advice, or by taking the person to an Emergency Room (ER) or Urgent Care Center where a triage nurse will determine the speed of response. If the implications of the emergency are uncertain, it helps to be at the ER to wait and see. That way, if the person takes a turn for the worse, getting medical help can take less time.



Call for Help

In general, one should always call **911** if the person:

- is or becomes *unconscious;*
- has *no pulse;*
- has *trouble breathing* or is *breathing* in a strange way;
- has *chest pain* or *pressure;*
- is *bleeding severely;*
- has *injuries to the head, neck, or back;* or
- has gone into *shock.*

If the above conditions do not apply, but any of the following is present, one should either call **911,** or POISON CONTROL, or take the person quickly to the Emergency Room at a local hospital:

- has persistent pressure or pain in the abdomen;
- is vomiting blood or has blood in bowel movement (red or black);
- has a seizure lasting 10 minutes or more;
- appears to have been poisoned;
- has possible broken bones, but can be moved without further damage;
- has systolic blood pressure reading over 200 (or under 80), or diastolic pressure under 50 (or over 120).

Regardless of the nature or extent of injury, as viewed at the scene, it is wise to call **911** if any of the following circumstances apply:

- fire or explosion;
- downed electrical wires;
- swiftly moving or rapidly rising water;
- presence of poisonous gas;
- vehicle collisions with injuries; or
- the person needs medical attention and cannot be moved easily.

What to do until medical help arrives

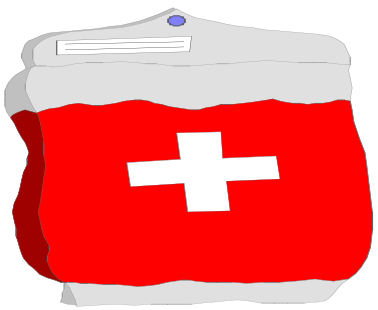
1. STAY CALM, so that you can reassure the person and not add to fear and concern, which in and of itself is understandable but not helpful.

2. STAY WITH THE PERSON.

3. MAINTAIN AIRWAY, if necessary by tilting the head back.

4. CONTROL BLEEDING, by application of pressure, or use of a tourniquet if necessary.

5. TREAT FOR SHOCK, by having the person lie down, loosen clothing, cover with a blanket, and seeking medical attention.



6. HAVE A CURRENT MEDICAL HISTORY READY TO GIVE TO THE PARAMEDICS TO INCLUDE, AT A MINIMUM

   - Name, DOB, current address, and phone#;
   - Current medications;
   - List of allergies;
   - Insurance information (for example, Medi-Cal card);
   - Information about what happened and when; and
   - Physician's name and telephone number.

It is a good idea to have *all* health information, including a copy of the person's health history and consent-to-treatment forms, in a separate folder. An excellent example is the *H.E.A.R.T. Wellness Journal*, developed under a Wellness Grant from the Department of Developmental Services, for Alta California Regional Center. (See Additional Resources, near the end of this *Resource Guide.)*

First Aid

Immediate, life-saving techniques are learned and are taught in first aid and CPR classes. First aid is required by Community-Care Licensing regulations. CPR is a great skill to have. The Red Cross and other organizations offer these classes.

Medical emergencies call for action. Some (not being able to breathe, and/or no pulse) call for immediate action on the scene. First aid techniques include:

- ✓ Abdominal Thrusts;
- ✓ Rescue Breathing; and/or
- ✓ Cardio-Pulmonary Resuscitation (CPR).

For example, common causes of choking include trying to swallow large portions of poorly chewed food; eating while talking excitedly or laughing; eating too fast; and walking, playing, or running with food or objects in the mouth. Signs and symptoms of choking include:

- clutching the throat with one or both hands;
- unable to speak, cough forcefully, or breath; and/or
- high-pitched wheeze.

If someone is choking, quick, upward abdominal thrusts (Heimlick Maneuver) will usually dislodge the object stuck in the person's windpipe.

Major injuries

Shock. – Major injuries can cause shock, as can exposure to some allergens (certain foods, medications). Bleeding, loss of body fluids, infection and lack of oxygen cause shock. Signs are pale bluish skin, moist clammy skin, weakness, rapid pulse, harder breathing, thirst, vacant expression, dilated pupils, and death.

Head/brain, neck, or back injuries. – Maintain airway, control bleeding, treat for shock, seek medical attention, immobilize if possible, and record the extent and duration of unconsciousness.

Broken bones. – Immobilize, splint (if time and materials permit), control bleeding, treat for shock, and seek medical attention.

Minor injuries

Wounds. – A "wound" is a break in the continuity of the tissues of the body, either internal or external. Accidents (for example, being hit by a car; falls; mishandling sharp objects) are the usual cause. First aid involves:

- ✓ stopping the bleeding (pressure bandage or direct pressure);
- ✓ protecting from contamination and infection;
- ✓ treating for shock; and
- ✓ obtaining medical attention, if needed.

Removal of foreign object. – Wood splinters and other items just under the skin can be removed by most people, using tip of sterilized needle or sterilized tweezers. A flame or boiling water will kill contaminants. If an object is embedded deeper in tissue or protruding, go to Doctor's office, the Emergency Room or Urgent Care Center.

Blisters caused by friction. – Best to leave unbroken; apply sterile dressing for protection from further irritation; treat as open wound is blister is broken (i.e., wash with soap and water; cover with sterile dressing).

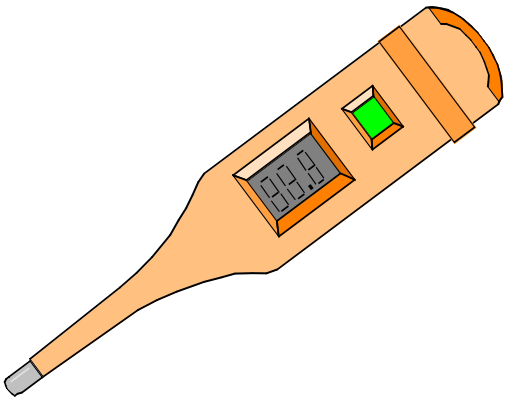
Burns. – Minor burns (for example, sunburn; contact with hot objects) are treated by submerging in water and applying a dry dressing if necessary. *Second degree* burns, which are deeper, causing blisters and being wet in appearance, are treated by immersing in cold (not ice) water, blotting dry, applying sterile dressing, avoiding ointments, and elevating limbs. *Third*

degree burns are those with complete loss of all layers of skin and a white, charred appearance, are treated by leaving clothes in tact, watching for possible breathing complications, not immersing in ice water (can cause shock), apply cold packs to face, hands, or feet for comfort, and seeking immediate medical attention.

Eye injuries/foreign objects. – Keep person from rubbing eyes; wash hands before examining eye; if not embedded, flushing with water. If embedded, applying dry dressing and seeking medical attention.

First aid supplies

Every community-care facility (CCF) must have the following minimum supplies at a central location within the home:



- a current edition of a *first aid manual* approved by the American Red Cross, the American Medical Association or a state or federal health agency.
- Sterile first aid dressings.
- Bandages or rolled bandages.
- Adhesive tape.
- Scissors.
- Tweezers.
- Thermometer.
- Antiseptic solution.

Make sure that you know where these supplies are in the home where you work.

Answers to In-Class Review

1. How do health assessments relate to health care plans? What are two elements of an initial health assessment?

Health assessments identify health problems or needs. Plans are developed in response to identified problems. Plans provide direction for DSP, health professionals, and others in assisting the individual to meet their needs. Plans include a means to determine if what is being done is having the desired effect. A current physical examination and a health history are two essential elements of a health assessment.

2. Why are physical examinations helpful?

Physical examinations are helpful in picking up health problems in early stages.

3. In helping people care for their teeth and nails, what should the DSP do?

Good dental hygiene contributes importantly to keeping one's teeth and avoiding the cost and pain of major restorations and other work (for example, deep scaling because of periodontal disease). The DSP should encourage and assist with such hygiene, and actually brush a person's teeth if the quality of their own brushing and flossing is inadequate. Fingernails, and especially toenails, need to be cut carefully and in a way (straight across) that avoids injury and infection. This is especially true for individuals with diabetes, circulatory problems, and toenail fungus. In these instances, a professional (for example, podiatrist) should typically cut toenails.

4. What should you do to get ready for an appointment with a health care professional?

Talk to the individual ahead of time about their health concerns. Have written questions or concerns ready to talk about the things important to the person. Be able to report signs and symptoms can be very helpful for the practitioner in coming up with a diagnosis. And, if medicine is prescribed, the physician will want to know what other medications (both prescription and over-the-counter) are being taken.

5. What is the relationship between the following: (a) observation; (b) change; (c) objective signs; and (d) subjective feelings?

Observation is based on sight, hearing, touch, and smell. Through these senses, the DSP is alert to change that can signal a health problem. Objective signs and symptoms are thing that an outsider (like the DSP) senses. Subjective signs (for example, pain, headache, dizziness, itching) are feelings of the person, and may (or may not) be conveyed through some form of communication. Sometimes, subjective feelings (for example, itching) coincide with objective signs or symptoms (for example, rash; scratching).

6. What is a medical emergency? When should a person call 911?

A medical emergency is an unexpected event calling for first aid, followed by prompt medical attention. In general, one should always call 911 if the person (a) is unconscious; (b) has no pulse; (c) has trouble breathing; (d) has chest pain or pressure; (e) is bleeding severely and it cannot be stopped; (f) has injuries to the head, neck, or back; or (g) has gone into shock.

If You Want to Read More About
Wellness

A Parent's Guide to Medical Emergencies

by Janet Zand, Rachel Walton, and Bob Roundtree (1997); Avery Publishing Group; ISBN: 0895297361

This book provides guidance for parents in meeting the emergency needs of their children.

Assessing Health Risk in Developmental Disabilities

By Karen Green McGowan & Jim McGowan (1995); McGowan Publications; ISBN: None

This book explains the rationale and use of KMG Fragility Scale.

First Aid Fast

by American Red Cross (1995); Stay Well Printer; ISBN: 0815102585

This booklet, complete with pictures and diagrams, indicates what to do in a variety of emergency situations.

Health and Wellness Reference Guide

by Smith Consultant Group and McGowan Consultants; developed for the Commission on Compliance, State of Tennessee (July 1998)

This is an excellent general reference for nurses and others working with direct care staff in various settings.

Health Care Protocols: A Handbook for DD Nurses

by McGowan Consultants and Smith Consultant Group; developed for the Commission on Compliance, State of Tennessee (August 1998)

This handbook contains a large number of Protocols to guide the treatment and management of various illnesses, injuries, and conditions.

Kaiser Permanente's Healthwise Handbook

by Donald W. Kemper, the Healthwise Staff, and Kaiser Permanente Physicians and Staff of Northern California (1998); Healthwise, Incorporated; ISBN: 1877930458

This handbook, distributed to members, contains a wealth of information related to self-care and when to get professional help. Part I covers Self-Care Basics, which includes using the Kaiser Permanente System, being a wise medical consumer, and prevention and early detection. Part II covers an array of health problems, including those of special interest to men, women, and children. Part III is about Staying Healthy, and covers mouth and dental problems, fitness and relaxation, nutrition, and mental wellness. Part IV, on Self-Care Resources, concludes the book.

Mayo Clinic Family Health Book

by David Larson, editor (1996); William Morrow & Company; ISBN: 0688144780

A revised edition of the popular medical reference contains updated data on more than one thousand diseases and disorders, facts on exercise and nutrition, and information about health-care options, stress management, the human life cycle, and more.

Nursing Assistants: A Basic Study Guide

by Beverly Robertson, MSC (1996); First Class Books, Inc.; ISBN: 1880246074

This Study Guide contains 16 Step-by-Step Modules and 32 Flash Cards, covering the fundamentals of being a competent Nursing Assistant in long-term care.

The [H.E.A.R.T.] Wellness Journal

by Health Concepts; developed for Alta California Regional Center (1998)

This handy, portable Wellness Journal, designed as part of a Wellness Grant from the Department of Developmental Services, can be carried by the person to meet with health care professionals. It contains personal background information, a health history, and log sheets for entries to be made. H.E.A.R.T. stands for Health Education Awareness Resource Tool. The Journal also includes a variety of resource tools, including pictorial/diagrams to assist individuals who use few if any words to communicate what they need and want.

The Merck Manual of Medical Information: Home Edition (1st Edition)

by Robert Berkow and others, editors (1997); Merck & Co.; ISBN: 0911910875

The world's best-selling medical reference is now available in every day language. Comprehensive, accurate information is offered, with contributions from more than 300 leading medical experts. 300+ illustrations.

Homework Assignment for Session #6: Positive Environment Checklist

Please complete the *Positive Environment Checklist* in the environment where you work and support people (licensed home, and/or other setting). There are some fairly easy to follow instructions on the first page of the checklist to assist you. Review each question and circle one of the answers given: YES, NO, or UNCLEAR (if the answer is hard to determine, or if it is sometimes "yes" & sometimes "no").

This tool is good to use for two main reasons:

1. By completing it, you may identify specific areas within the environment, that may need to be looked at more closely, as they may impact the behavior of the people you are supporting. DSPs and/or administration may be able to adapt or change some of these areas to improve the quality of services you provide.

2. This is a good "self-assessment" tool that you can use to grade your environment. You may find that you are already positively addressing the areas listed and can "pat yourself on the back" with the results.

   Your results should be brought with you to the next session. We will discuss the following questions:

   a) what area(s) did you rate well on (circling "YES" responses).

   b) what areas did you rate "NO" or "UNCLEAR" on.

   c) of the areas rated "NO" & "UNCLEAR," what suggestions do you have to make any practical changes within the learning environment to address those needs (or, have you done so already)?

POSITIVE ENVIRONMENT CHECKLIST*

The Positive Environment Checklist (PEC) is designed for use in evaluating whether the settings in which persons with moderate to severe disabilities live, work and go to school are structured in a manner that promotes and maintains positive, adaptive behaviors. The PEC looks at whether settings provide the conditions that support positive behaviors and do not present conditions that make negative behaviors more likely. It also addresses several concerns related to the ways in which program staff support and interact with the people with disabilities in the setting.

The checklist should be used as part of a proactive, preventive approach to addressing challenging behaviors. The checklist can be used as a general tool to provide an overall assessment of a setting. Also, when a particular individual is selected, it can be used as part of a comprehensive analysis of challenging behavior(s) to determine whether environmental conditions are contributing to it.

The PEC focuses on the physical, social, and programmatic structure of the environment. Checklist questions are divided into 5 sections:

1) Physical Setting,
2) Social Setting,
3) Activity & Instruction,
4) Scheduling and Predictability, and
5) Communication.

Responses to questions in each area should be based on direct observation of the environment, review of written program documents and personnel. Three response options are provided for each question: **YES, NO**, and **UNCLEAR.** The term "staff" applies to paid and volunteer personnel who provide support and services in the setting. The term "people" refers to the people with disabilities who live, work, or attend school in the setting.

Scoring the completed PEC is simply a matter of determining which questions received a **YES** response, and which received **NO** or **UNCLEAR** responses. **NO** responses indicate areas or issues that should be addressed to create a more positive environment. **UNCLEAR** responses indicate the need for further analysis, perhaps by extended observation or by questioning a larger number of program personnel.

* *R & T Center on Community Referenced Positive Behavior Support*
University of Oregon

SECTION 1: PHYSICAL SETTING

1.	Is the physical setting clean, well lit and odor free?	YES	NO	UNCLEAR
2.	Is the temperature regulation in the setting adequate?	YES	NO	UNCLEAR
3.	Is the physical setting visually pleasant and appealing?	YES	NO	UNCLEAR
4.	Does the arrangement of the setting promote easy access for all individuals within the setting?	YES	NO	UNCLEAR
5.	Is the setting arranged in a manner that facilitates needed staff support and supervision?	YES	NO	UNCLEAR
6.	Does the setting contain or provide interesting, age-appropriate items and materials for people to use?	YES	NO	UNCLEAR
7.	Is the setting located and structured in a manner that promotes and facilitates physical integration into the "regular" community?	YES	NO	UNCLEAR

SECTION 2: SOCIAL SETTING

1.	Is the number of people in this setting appropriate for its physical size and purpose?	YES	NO	UNCLEAR
2.	Are the people who share this setting compatible in terms of age, gender and support needs?	YES	NO	UNCLEAR
3.	Do the people that share this setting get along with each other?	YES	NO	UNCLEAR
4.	Do staff actively work to develop and maintain a positive relationships with the people here?	YES	NO	UNCLEAR
5.	Do staff promote and facilitate opportunities for social integration with people who are not paid to provide service?	YES	NO	UNCLEAR

SECTION 3: ACTIVITIES AND INSTRUCTION

1.	Do people participate in a variety of different activities?	YES	NO	UNCLEAR
2.	Do people participate in activities that occur in regular community settings outside of the home, school or workplace?	YES	NO	UNCLEAR
3.	Do people in this setting receive instruction on activities and skills that are useful and meaningful to their daily lives?	YES	NO	UNCLEAR
4.	Is the instruction that people receive individualized to meet individual needs?	YES	NO	UNCLEAR
5.	Are peoples' personal preferences taken into account when determining the activities and tasks in which they participate and receive training?	YES	NO	UNCLEAR

SECTION 4: SCHEDULING AND PREDICTABILITY

1.	Is there a system or strategy used to identify what people in this setting would be doing and when?	YES	NO	UNCLEAR
2.	Is there a means to determine whether the things that should be occurring actually do occur?	YES	NO	UNCLEAR
3.	Do people in this setting have a way of knowing and predicting what they will be doing and when?	YES	NO	UNCLEAR
4.	Do staff prepare people in this setting in advance for changes in typical schedules or routines?	YES	NO	UNCLEAR
5.	Do people in this setting have opportunities to exercise choice in terms of what they will do, when, with whom & what rewards they will receive?	YES	NO	UNCLEAR

SECTION 5: COMMUNICATION

1.	Do people in this setting have "acceptable" means to communicate basic messages (e.g., requests, refusals, need for attention) to staff or others in the setting?	YES	NO	UNCLEAR
2.	Do staff promote and reward communication?	YES	NO	UNCLEAR
3.	Do staff have "acceptable" means to communicate basic messages to the people in this setting?	YES	NO	UNCLEAR